Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
SIERRA MEDICAL CENTER
1625 MEDICAL CENTER DRIVE
EL PASO TX 79902

Carrier's Austin Representative Box
#19

Respondent Name
FACILITY INSURANCE CORP

MFDR Date Received
MARCH 5, 2007

MFDR Tracking Number
M4-07-4170-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The Request For Reconsideration Letter Dated February 21, 2007: " According to Worker Compensation statue [sic] the stop-loss threshold is reached once charges exceed $40,000.00 and reimbursement admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%. Our claim should have been processed as follows: Total Charges: $76,042.86…Implant charges: $53,809.55…$22,233.31 x 75% = $16,674.98…Implant Cost plus 10% = $14,899.50…Total Reimbursement = $31,574.48."

Amount in Dispute: $12,765.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated March 30, 2007: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $18,809.20 or less represents an amount greater than or equal to the fair and reasonable reimbursement for this service…Because Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further reimbursement. **The Carrier otherwise requests a refund**…"

Respondent's Supplemental Position Summary Dated September 8, 2011: "Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception."

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 10, 2006	Outpatient Hospital Services	$12,765.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W10 – No maximum allowable defined by fee guideline. Reimbursement based on insurance carrier fair and reasonable reimbursement methodology.
- B15 – Included in the ASC Group Rate.
- W10 – Reimbursed at 213.3% of Medicare's current adjusted ASC Group rate.
- W10 – Reimbursement based on 100% of the current Medicare ASC Group Payment rate for the primary surgical procedure. All subsequent surgical procedures reimbursed at 50% of the current Medicare ASC Group rate.
- 18 – Duplicate claim/service.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "According to Worker Compensation statue [sic] the stop-loss threshold is reached once charges exceed $40,000.00 and reimbursement admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%."
   - According to 28 Texas Administrative Code §134.401(a)(3), the Acute Care Inpatient Hospital Fee Guideline is not applicable to hospital surgical outpatient services; therefore, the disputed services are not applicable to the SLRF of 75%.
   - The requestor does not discuss or explain how additional reimbursement of $12,765.28 supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.

- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

  Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/28/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.